59th Medical Wing

59 MDW Neurology Product Line Analysis Departmental Response

Information Brief

Briefer: Lt Col Wicklund

Date: 6 Jan 2005

Wilford Hall Medical Center **Neurology**

Future…

Present…

Past…

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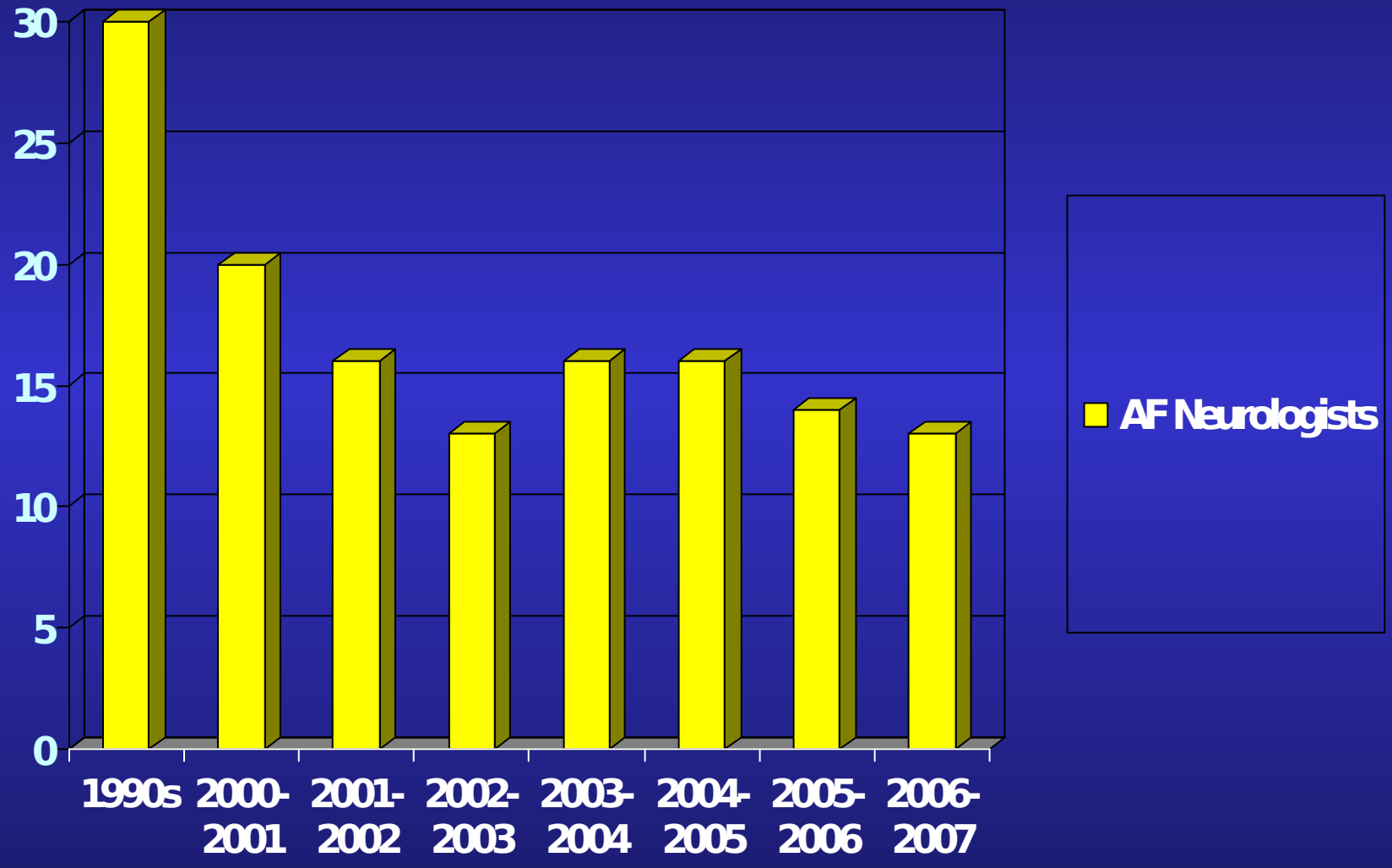
Lt Col, USAF, MC
Chairman, Department of Neurology

Past

- WHMC Neurology - 1990s
  - 6-9 staff neurologists
  - One staff neurologist at Brooks
  - 9 total residents (3 per PGY year group)

Historical Air Force Wide Neurology N



Present

- **Patient Care**
  - COMPREHENSIVE
    - One of few WHMC clinics seeing all beneficiary categories
    - We send nothing downtown
  - SPECIALIZED
    - Only epilepsy center in USAF and most active center in DoD
    - Only neuromuscular center in USAF
    - Worldwide referral center - consultations from every continent except Australia and Antarctica in 2003
  - CUTTING EDGE
    - Sole location in North America treating prion diseases with intraventricular pentosan polysulfate
      - Only four other patients worldwide receiving this therapy
  - COOPERATIVE
    - WHMC supports BAMC with sub-specialty coverage
    - Prime patient consultations
    - Epilepsy monitoring
    - Neuromuscular to include: consultations, EMGs, muscle biopsies, Botox
    - GME – for BAMC IM residents

Present

- **Readiness**
  - FLYERS
    - Primary neurological support to Aeromedical Consultation Svc
      - Previously full time position at Brooks
  - WARFIGHTERS
    - Defense Veterans Brain Injury Center
      - DoD/VA congressionally funded program
      - Support to OIF/OEF casualties
      - Case management, consultation and research into mild, moderate and severe brain injury
  - EDUCATORS
    - Senior editors of the *Neurologic Clinics of North America* issue in May 2005 on Neurological Toxins and Weapons

Present

- **GME**
  - EXCELLENCE
    - Residency Program is Wilford Hall stand alone
    - RRC Status: 5-year accreditation – Next accreditation - 2008
    - Overall Program Health: Excellent, but guarded
      - Board Certification Pass Rate – 100% for 15 years
    - Scores: Program usually in top 5%, always in top 15%
      - Top score in nation on in-service exam in 2003
      - 98th percentile in 2004
    - Has produced university chairmen and vice-chairmen of neurology

Present

- **Research**
  - FORWARD THINKING
    - Sponsors neurological research (particularly military unique topics)
    - 10-20 publications each year
    - Research presentations annually at our annual Academy meetings
    - Our faculty teach the courses at this national meeting

Neurology Department
Staffing - multitasking

- Lt Col Wicklund - .50 FTE
  - **Chairman**
  - **Neurology Consultant***
- Lt Col Jaffee - .30 FTE
  - **Program Director**
  - **DVBIC PI***
  - **ACS support*#**
- Maj Richards - .25 FTE
  - **3/4 time peds neuro***
- Contractor - 1.0 FTE

- Lt Col Avery - .50 FTE
  - **Flight Commander**
  - **Geriatrics Consultant***
  - **Sole WHMC geriatrician***
- Maj Grogan - .80 FTE
  - **Training Officer**
- Maj Dobbs - .80 FTE
  - **Research Coordinator**

- **FTEs: Now = 4.15**
  2000 = 7.65

*** = previously not in the Department**
 # = previously a full time neurologist at Brooks AFB

Present

- Neurology PLATT
  - Just approved by AFMSA

Neurology Clinic CCA Detail

Model Elements	Benchmarks	Comments
Neurologist (44N3)	**1: 43,478** (2.3/100K)	• Group Health of Puget Sound, Seattle; Group Health Foundation, Minneapolis • **GME adjustments/additives**
Support Staff (PAA) **Nurse** **Medical Technician** **Admin Support**	**0.3** **1.5** **0.5**	• Nurse FTEs earned with other IM subspecialties • Round up at 0.5 • **Assumption: Neurology co-located with other IM shreds**
Productivity Target Neurologist:	7,980 RVUs	• 2002 50th percentile for UHC • 6,508 – 2002 AFMS average
Facility Requirements	2 treatment	• DOD Medical Space Planning

Neurology Clinic BCA

ECA	
Primary:	No UTC requirements
Substitute:	Not a substitute for other AFSCs
CCA	
Target Benchmark:	1 per 43,478 Population Served
Support Staff:	46N3: 0.3 4NX0: 1.5 4AX0: 0.5
Target RVUs:	7980 RVUs/provider
BCA	
Total Revenue per PAA Block:	**$577,787**
Total Expense:	**$336,314**
Expected ROI:	**$208,473**

Worst-case revenue per RVU is used which is based upon the lowest geographic reimbursement rate of all AFMS MTFs, currently the South Carolina rate, $82.60. "Average" and individual revenues would actually be higher.

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Target RVUs:	7980 RVUs/provider
BCA	
Total Revenue per PAA Block:	**$288,796**
Total Expense:	**$316,580**
Expected ROI:	**($27,784)**

The geo-locality adjusted average total RVU of $36.19 was used as a conservative app for estimating the return on investment.

Future

- Data Quality
- Regional Cooperative Care for Neurology Services
- Medical and Financial Improvements
- Suggestions

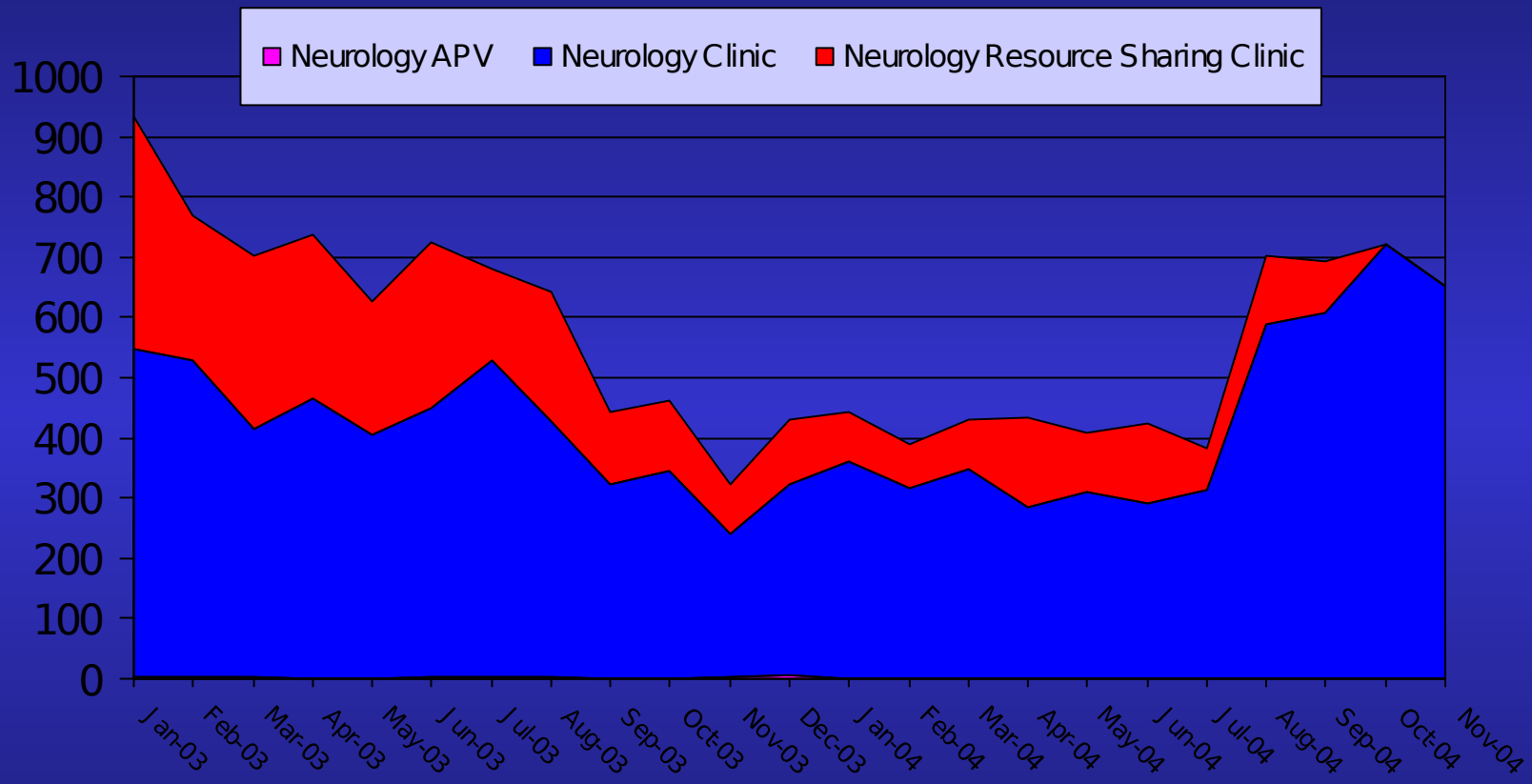
Future

- **Data Quality**
- Regional Cooperative Care for Neurology Services
- Medical and Financial Improvements
- Suggestions

Since our initial brief

- Met with Maj Weitzel of ENT the same day
  - Reviewed his brief
- Our method
  - Templates set up for maximal billing
    - ROS key documentation point for billing
    - Templates
    - “Coding Made Ridiculously Simple” briefings to our residents and staff
  - Coding some telecons – previously lost as patient counts
  - Coding inpatient consults – previously lost as patient counts
  - EEGs / EMGs– lost as patient counts and for billing

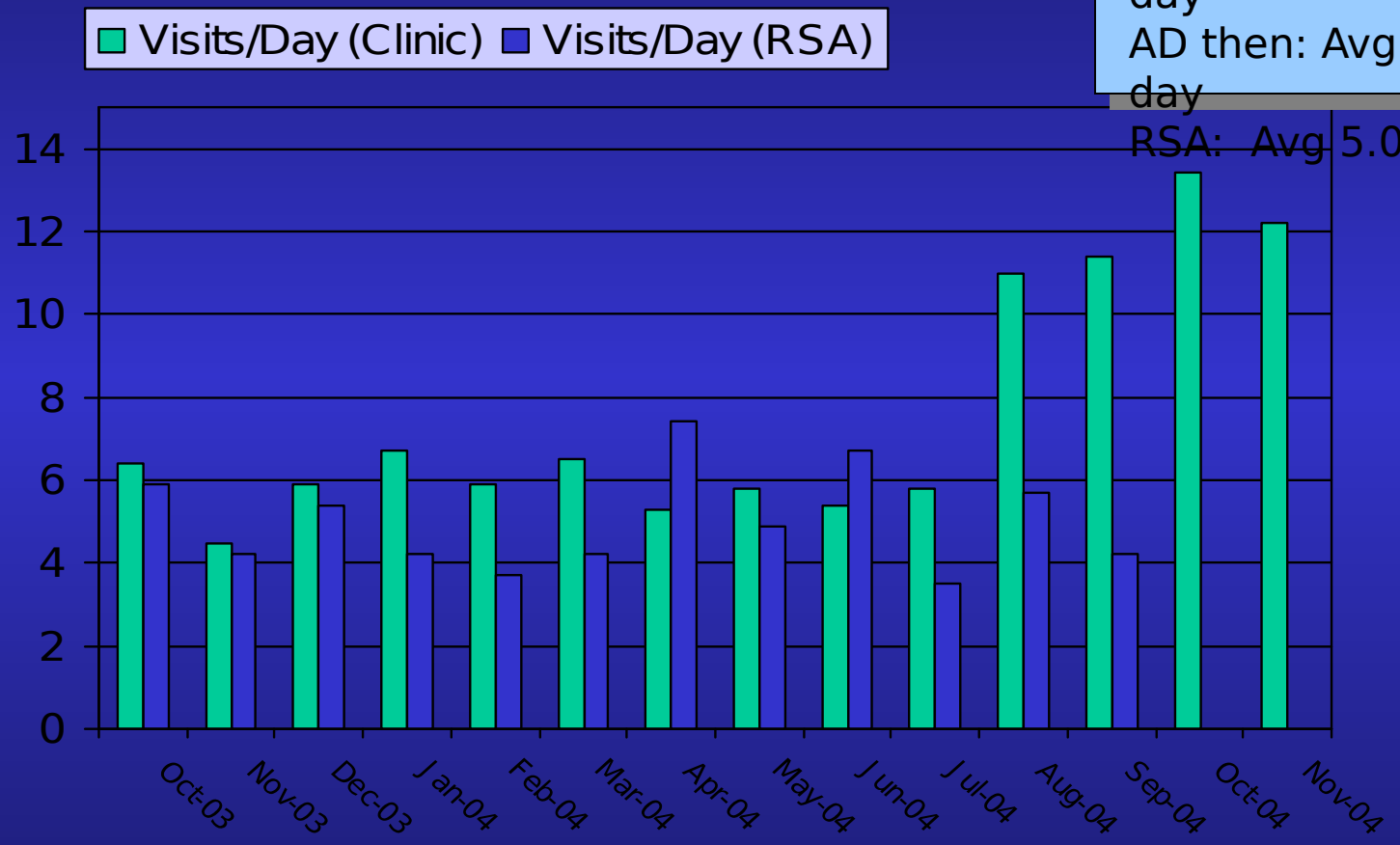
Neurology
Total OP Visits 2003-2004



- **Past four months: 692/mo**
  - **Actual Δ = -6%**
- FY04 Avg (to date): 460/mo
  - Δ = -38% Δ
- FY03 Avg: 739/mo

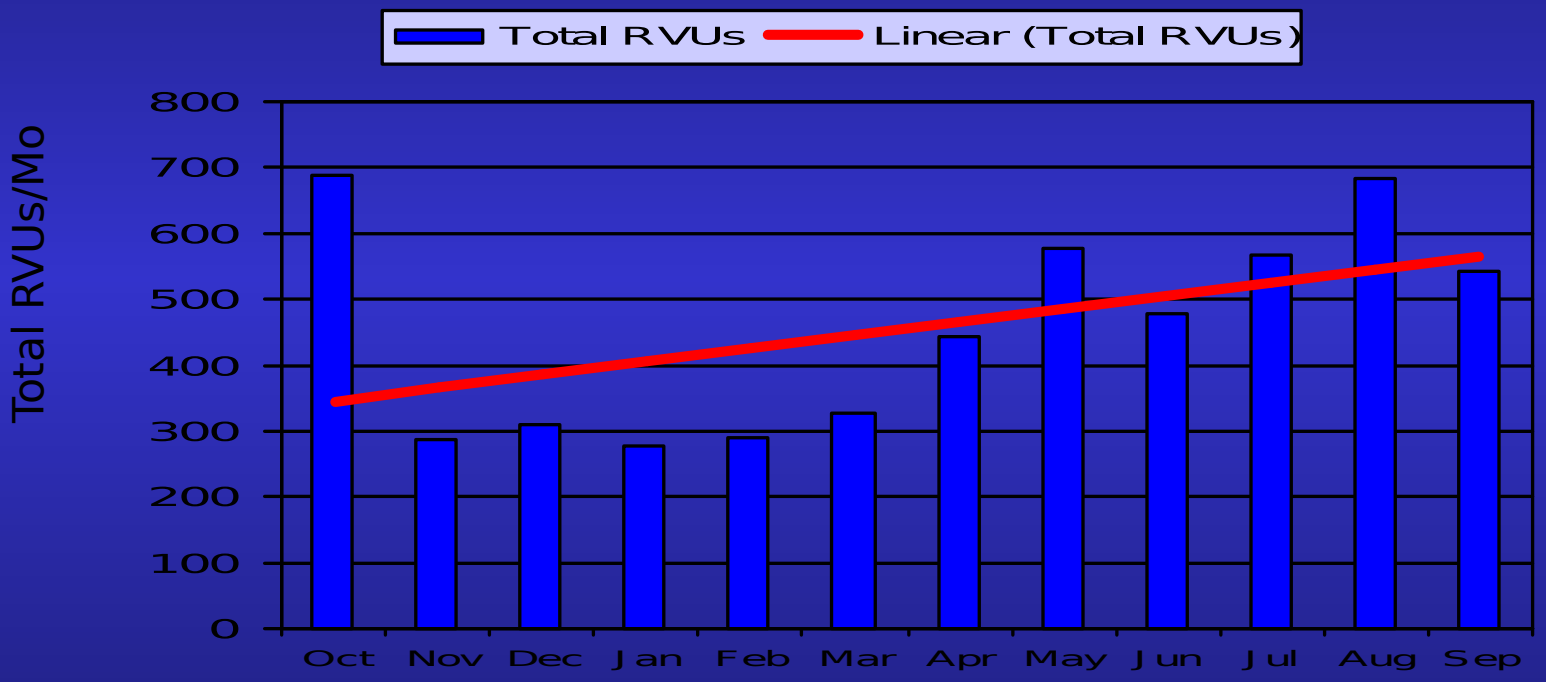
Neurology
FY04 OP Visits/FTE/Day*

AD Now: Avg 12.1 per day
AD then: Avg 6.7 per day
RSA: Avg 5.0 per day



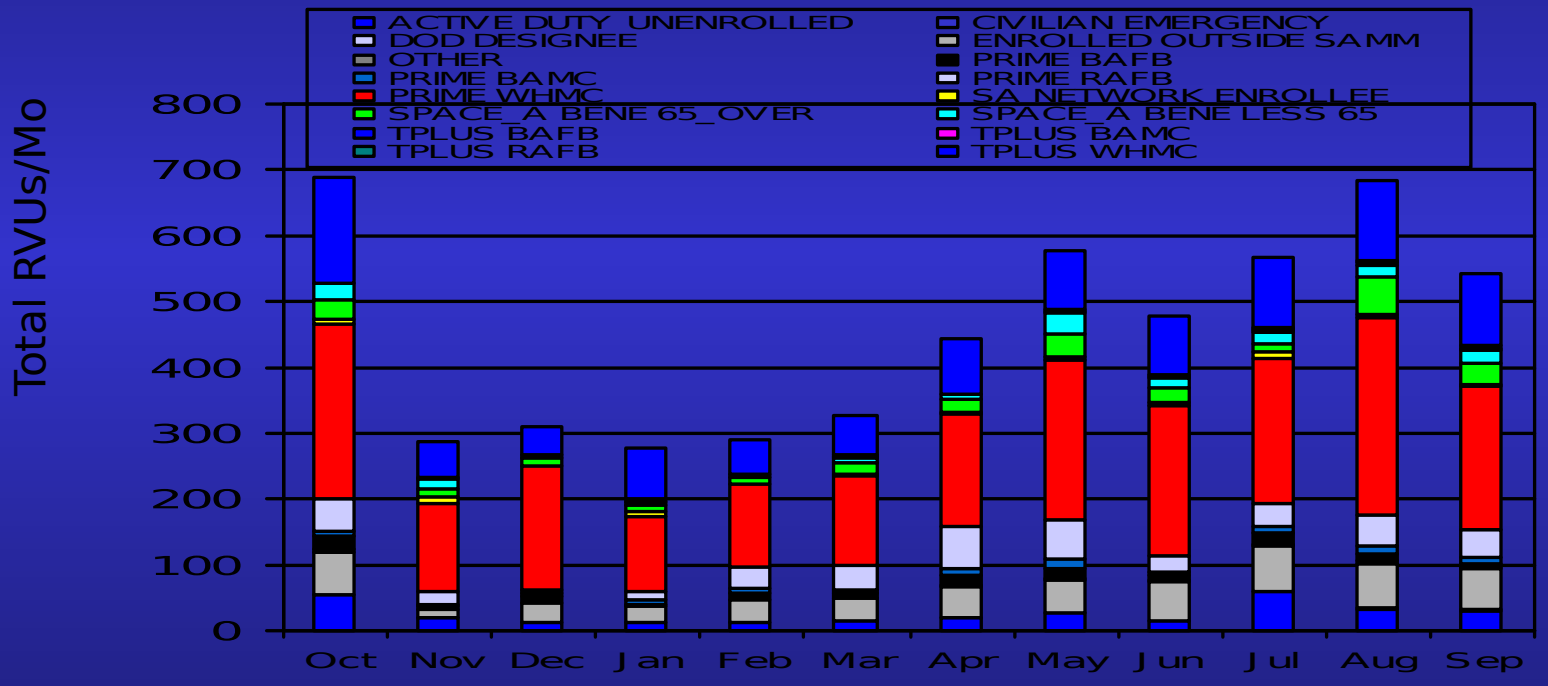
- FY 2004 RSA = 1 FTE & 5 AD staff = 2.68 FTE
- FY 2005 Contractor = 1 FTE and 5 AD staff = 2.68 FTE
- MEPRS shows 2.4 total

Neurology
Total RVUs FY04



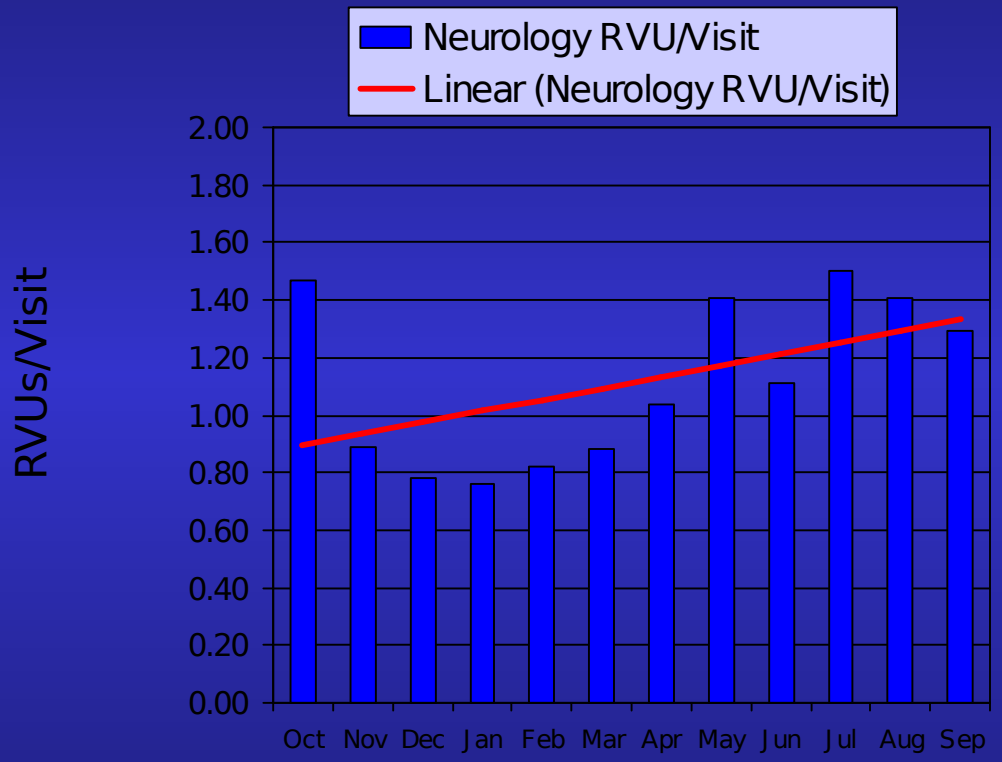
- WHMC Avg: 456/mo and increasing

Neurology
Total RVUs FY04 (by Enrollment Type)



- WHMC Avg: 456/mo

Neurology
Total RVUs/Visit FY04

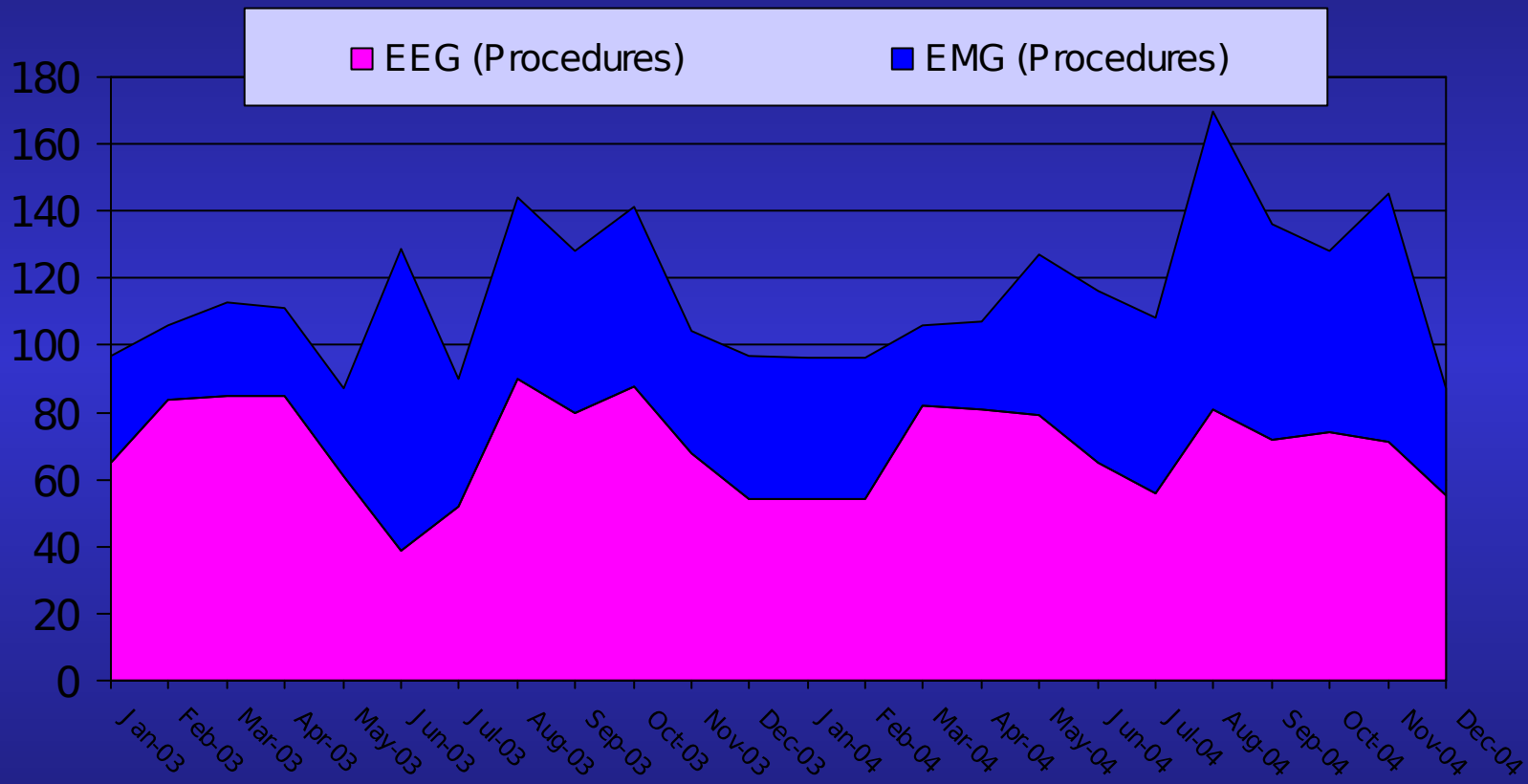


- FY03 Avg: 0.90 RVUs/visit
- FY04 Avg is **1.14** RVU/visit
- May thru Sep 04: Avg increased to **1.35** RVUs/visit

Since our initial brief

- Met with the Pit Crew
- Met with Maj Parks Gibson and coders
  - Productive interchange of ideas
    - Some systems problems inhibited optimal billing
  - Will now get feedback on our audits
  - May obtain a coder
  - Not unhappy without one
    - Highest reimbursement rate

Neurology
EEG/EMG 2003-2004



- EEG: down 3% to 69/mo
- EMG: up 20% to 50/mo

Since our initial brief

- Extreme frustration with change in MEPRS coding from BAKA to DDBA (EEG) and DDCA (EMG)
  - Both “D” codes are non-counts and non-billable
- Reviewed the EIC site under:

  “Standardized AF Workload Capture Guidelines”
- Revealed the following table:

Issue	Definition	Coding	Workload Count	Billable
ECG, **EEG**, cardiography, echo, pulmonary **etc**.	• **EEG**/ECG/PFT/Holter, events monitor/ambulatory BP monitor is accomplished in a separate clinic (ER, flight medicine, family practice) EEG/ECG/PFT/Holter, events monitor/ambulatory BP monitor accomplished centrally in the cardiopulmonary lab Tests done with the provider present (e.g. **EMG**, stress test, cardiolite, pulmonary stress test, tilt table tests, etc)	**E&M: Appropriate codes for privileged provider's visit, CPT for procedure** ADS is not used **E&M: Appropriate codes**	• **Technician is listed as an additional provider; activity is not a separate encounter but is considered as part of the privileged provider's visit** • Workload in appropriate DD** MEPRS code • **NOTE**: Tests interpreted by provider other than the ordering provider are currently not captured as workload. The provider's time should be captured under the appropriate DD** MEPRS code. • **"Count" visit in privileged provider's "B" MEPRS code. Technician is listed as additional provider**	**Y** N **Y**

Data Quality

- Return to coding EEGs and EMGs as physician counts as recommended above => markedly increased billing and appropriate documentation of physician workload.

  EEGs: 70/mo at ~ $220/study

  => $16,000/mo and **$200,000/yr**

  EMGs: 50/mo at ~ $1000/study

  => $50,000/mo and **$600,000/yr**

Data Quality

- AAAA => AAJA
  - 2 years ago we noted that roughly 1/3 of our inpatient's charts were being credited to internal medicine (AAAA) and not neurology (AAJA)
    - Internal medicine interns rotate on the neurology ward service
    - Cognizance

Future

- Data Quality
- **Regional Cooperative Care for Neurology Services**
- Medical and Financial Improvements
- Suggestions

Regional Cooperative Care for Neurology Services

- BAMC
  - Discussions with their Chief of Neurology Services
    - Journal club
    - EEG techs
    - Physician exchanges
    - Residents at BAMC
  - BRACC?

- UTHSCSA
  - GME – discussions with UT Neurology Program Director
    - WHMC Neurology inpatient service too small
    - WHMC losing critical mass to support stand alone GME programs
    - Expanded affiliation
      - Especially for inpatient ward experiences

Regional Cooperative Care for Neurology Services

- North Side
  - Consideration to placing a single neurologist at Randolph or Camp Bullis 1-5 days per week
- Regional
  - For the 9 months we have been contacting some of the regional USAF medical facilities in an outreach program
  - Win, win, win
    - Us – GME
    - Them – ready access to quality neurology care
    - Us – Facility recoups credit?

Future

- Data Quality
- Regional Cooperative Care for Neurology Services
- **Medical and Financial Improvements**
- Suggestions

Medical and Financial Improvements

- Due to our current business practices
  - CHCS II should not be a work slowdown

Medical and Financial Improvements

- Transcranial Doppler
  - Potential to decrease use of MRIs (studies/year)
    - Pediatrics (100-200)
      - ~ $1500 - $3000 per MRI
      - Likely ~ **$200,000** total
    - Adult (100-200)
      - ~ $1500 per MRI
      - Likely ~ **$200,000** total
  - Excellent GME benefit
  - Requirement
    - Release of funds
      - Purchase (approved/funded) **($29,000)**
      - Update in operator training **($12,000)**

- Epilepsy Monitoring
  - We did
    - Over 40 cases last year
    - ~ $3000/day in network
  - We have
    - The equipment
    - Physician expertise and time
  - We lack
    - Experienced monitoring technician
    - RSA technician's contract thought to be tied to our RSA neurologist – position terminated
  - We need
    - ~ **$35,000** annually in salary
  - We save
    - ~ **$300,000** annually in costs to network

Future

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- **Suggestions**

Suggestions

1. Advertise that a portion of 3rd party billing will go back to each Department for their use (equipment purchase, TDY, furniture upgrades, etc.)
2. Treat WHMC as a university hospital encouraging research grants (take a 20-40% cut on grants just as the University's Dean would)
3. Consider setting up a Center for Geriatrics Medicine through Jackson / True / Fact:
    - This might allow for billing of Medicare for >65 patients
4. Require that all personnel trained in a clinical specialty (at the squadron level and below) work in that clinical specialty for at least one full shift weekly. Triple benefit:
    - Increased productivity
    - Supervisors better acquainted with their duty sections
    - Less time available to generate taskers

Summary

- Data Quality
  - Improving, especially with better interchange of info
  - Recoup EMG/EEG counts and billing
  - Should become profitable
- Regional Cooperative Care for Neurology Services
  - Expanded interactions with BAMC
  - Residency with greater affiliation with UT
  - North side neurology assets?
- Medical and Financial Improvements
  - CHCS II should not be a big impediment
  - Epilepsy monitoring and TCD

Bid Price Adjustment

- The data reported do not correlate with other reported data.